

DIVISION OF DEVELOPMENTAL DISABILITIES  
**WAIVER ENROLLMENT REQUEST**

DDD Division of Developmental  
Disabilities

**CLIENT INSTRUCTIONS:** Please fill in Client Name, DDD Number (if known), Date of Birth, Referral Date (date of request), Region Number (if known) and Case Manager's Name. **All other information is to be filled out by DDD staff.**

**Send** this form to your Case Manager or take it in to your local Division of Developmental Disabilities Office.

CLIENT NAME		DDD NUMBER	DATE OF BIRTH	REFERRAL DATE
REGION	CASE MANAGER	<input type="checkbox"/> Referral to a different Waiver <input type="checkbox"/> New waiver referral		

**LEGAL AUTHORITY**

WAC 388-845-0045 "When there is capacity to add people to a waiver, how does DDD determine who will be added?"  
 WAC 388-845-0050 "How do I request to be enrolled in a waiver?"  
 WAC 388-845-0070 "What determines if I need ICF/MR level of care?"

**REQUEST FOR CHANGE OF WAIVER ASSIGNMENT (Complete only for current waiver clients)**

CURRENT WAIVER ASSIGNMENT	REQUESTED ASSIGNMENT
<input type="checkbox"/> Basic <input type="checkbox"/> Basic Plus <input type="checkbox"/> Core <input type="checkbox"/> CP	<input type="checkbox"/> Basic <input type="checkbox"/> Basic Plus <input type="checkbox"/> Core <input type="checkbox"/> CP

**PRIORITY PER WAC 388-845-0045 (Complete for all requests)**

Choose only one priority (1, 2, 3 or N/A)

- ☐ 1. Individual is currently on a waiver but requires a different waiver to meet their needs.
- ☐ 2. Priority populations: (select one of the following)
- ☐ Member of a group identified and funded by the legislature.
  - ☐ In immediate risk of ICF/MR admission due to unmet health and safety needs.
  - ☐ Is a risk to the safety of the community.
  - ☐ Currently receiving services through state-only funds.
  - ☐ Persons on an HCBS waiver that provides services in excess of what is needed to meet their identified Health and Welfare needs.
  - ☐ Persons who were previously on an HCBS waiver since April 2004 and lost waiver eligibility per WAC 388-845-0060(9)
- ☐ 3. Needs Basic waiver services to remain in their family's home.
- ☐ N/A Does not meet any of the above criteria.

**ICF/MR ELIGIBILITY PER WAC 388-845-0050 (Complete for all requests)**

- ☐ Determined to meet ICF/MR level of need per the 15-168 or the 15-170A.
- ☐ Does not meet ICF/MR level of need. **STOP! DO NOT PROCEED IF NOT ICF/MR ELIGIBLE.**

**IDENTIFY THE SPECIFIC TARGETING CRITERIA FOR THE WAIVER THAT REFLECTS THIS INDIVIDUAL'S NEEDS  
(Complete for all requests)**

<b>Basic Waiver</b>	<input type="checkbox"/> Lives with family or in their own homes. <input type="checkbox"/> Has a strong natural support system. <input type="checkbox"/> The family/caregiver's ability to continue caring for the individual is at risk, but can be continued with the addition of services. <input type="checkbox"/> Does not need out-of-home residential services.
<b>Basic Plus Waiver</b>	<input type="checkbox"/> Lives with family or in another setting with assistance but is at <u>high</u> risk of out-of-home placement or loss of current living situation. <input type="checkbox"/> Needs to live in an adult family home or adult residential care facility. <input type="checkbox"/> Requires more than \$6,500 per year in day program services.
<b>Core Waiver</b>	<input type="checkbox"/> Requires residential habilitation services outside of the parent's home. <p style="text-align: center;">or</p> <input type="checkbox"/> Lives in the parent/family home, but is at <u>immediate</u> risk of out-of-home placement without more services than can be provided in the Basic Plus Waiver.

**Community  
Protection  
Waiver**

- ☐ Lives or is moving into the community; and
- ☐ Requires 24-hour, on-site, staff supervision to ensure the safety of others; and
- ☐ Requires therapies and/or other habilitation services; and
- ☐ Meets the DDD criteria for "community protection."

**RECOMMENDED CENTRAL OFFICE RESPONSE TIMELINE (Timeline reflects critical need for waiver services)**

- ☐ **Emergent (<24 hrs.) Client is in immediate jeopardy and has no support available.**
- ☐ **Within 30 days. Will lose current critical supports within 30 days.**
- ☐ Not emergent.
- ☐ Other (explain):

**CURRENT LIVING SITUATION**

- |  |  |
|--|--|
| <input type="checkbox"/> Homeless  | <input type="checkbox"/> Adult living with parent                        |
| <input type="checkbox"/> Own home with no paid or unpaid support         | <input type="checkbox"/> Psychiatric hospital                            |
| <input type="checkbox"/> Own home with insufficient residential supports | <input type="checkbox"/> Medical facility                                |
| <input type="checkbox"/> Child living with parent/family/guardian        | <input type="checkbox"/> Jail/correctional facility                      |
| <input type="checkbox"/> Adult living with elderly parent (65 or over)   | <input type="checkbox"/> Child under age 22 in non-DDD foster/group home |
| <input type="checkbox"/> Adult living with non-relative                  | <input type="checkbox"/> Other:  |

**REGIONAL ADMINISTRATOR**

- ☐ Recommend Approval
- ☐ Recommend Denial

Comments:

REGIONAL ADMINISTRATOR OR DESIGNEE

DATE

**CENTRAL OFFICE APPROVAL**

- ☐ Approved
- ☐ Denied

Comments:

WAIVER PROGRAM MANAGER OR DESIGNEE

DATE

**NEW WAIVER REFERRAL - FOR CENTRAL OFFICE USE ONLY**

**RECOMMENDED WAIVER ASSIGNMENT**

☐ Basic    ☐ Basic Plus    ☐ Core    ☐ CP